NOV. 30, 2004 3: 30PM



10. 279

DISCLOSURE AUTHORIZATION

Claimant's Name (Please Print):

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, medically related facility or association, medical examiner, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar orally to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and commedical information or records that they may have concerning my health condition, or health blatery, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not finited to: cause, treatment, diagnoses, prognoses, concultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not timited to, information concerning: mental ilhess, psychiatric, drug or sicohol use and any dicability, and also HIV related testing, infection, illness, and AIÖS (Acquired Immune Deficiency Synchome), as well as communicable diseases and genetic testing. If my plan administrator operators both a disability plan upder whiten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this folio may also be given to any CiGNA Company which administrate such medical or disability benefits for the purpose of evaluating any ofalm that may be submitted by me or on my behalf for benefits, for evaluating return to employment opportunities, and for noministering any loature described in the plan. This information may also be extigoted for use in audits or for statistical purposes.

AUTHORIZE: any financial inatitution, accountant, tax preparer, insurance company or retinuter, consumer reporting agency, insuranco suppon organization, Claimant's agent, employer, group polloyholder, business associate, benefit plan administrator, family members, friends, neighbors or aspociates, governmental agency including the Social Security Administration or any other organization or person having knowledge of the to give the Company or the Plan Administrator or their employees and suthorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, earnings or finances, applications for insurance coverage. prior claim likes and cialin history, work higtory and work related activities.

I UNDERSTAND: the Information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim banatis, any amounts psychia, return to employment opportunities, and to administer the other feature described in the plan with respect to the Cisiment. This authorization shall minain valid and soply to all records, information and events that occur over the cumition of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and I or my authorized representative may request one, I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be disclosed to snyone EXCEPT: a) mineraling companies; b) the Medical Information Bureau, Inc., which operates Health Cigim Index (HCI): c) fraud or overlasurance detection bureaus; d) anyone performing business, medical or legal bundlins with respect to the claim or the plun, including any entity providing avaistance to the Company under its Social Sociality Assistance Program and employers involved in return to employment discussions; e) for audit or statistical purposes; f) as may be required or possitived by law; e) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

it my medical information contains information regarding drug or arothol abuse, I understand that my records may be protected under federal (42 OFR Part 2) and some state laws. To the extent permitted under laiv, I can ask the party that disclosed information to the Company to pennit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so, Company may deny my claim for bonelite pursuant to the plan. The use and turbor declosure of information disclosed hereunder may popole subject to the Health Insurance Portability and Accountability Act (FIPAA).

Signature of Claimant or

Claimani's Authorized Representative: *

Relationship.

if other than Claimant:

Company Name:

Claiment's Social Security Number: 6

PROHIBITION ON RE-DISCLOSURE

If the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Federal regulations (42 CFR Part 2) prohibit any person or onliky who receives such protected information from the Company from making any lumber disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of modical or other information is not sufficient for this burpage. The federal rules restrict any use of such protected information to criminally investigate or prosecute any elcohol or daug abusa patlent.

Alexnov. 30, 200420 3: 30 PM 41 - 4HY2

80, 279 f. 6

09/14/04 107486 7701200

CERVICAL SPINE MINIMUM 4 VIÊNS rinal

Ordered: 09/14/2004

RADIOLOGY REPORT.

Location: COMPRH CARE-HT4

Name: ALFANO, STEVEN MRN: (00000)002284147.

Order time: 0929

Age: 46 YRS Sex: M DOB:01/14/58

Admitting M.D.: ROACH, KEITH W DR. HD

Order M.D. Exam Ordered:

EXAM DATE: Accession #: ROACH, KEITH W DR. NO 09/14/04 01-RA-04-107486 CSP 4 V

FINDINGS:

Clinical History: Neck pain. Lumbar stenosis.

Technique: Frontal lateral and oblique views of the cervical spine. Five

views.

Comparison: None

Findings: Degenerative disk disease with disk space parrowing noted at C6-C7. Uncal-vertebral joint osteophyte narrows the neural foremen at this level greater on the left than the right. Remainder of examination is normal. Alignment is normal and there is no evidence of fracture or dislocation. Regional soft tissues and osseous structures are normal.

IMPRESSION:

Degenerative disk disease with disk space narrowing and osteophyte formation at C6-C7. Left foreminal narrowing secondary to uncal vertebral joint osteophyte formation.

DIAGNOSIS:

01RA04107486

study interpreted and report approved by: Robert D. Zimmerman M.D.

Electronically signed Diagnostic Imaging Report

14SEP200/ 14SEP2004/ RZ

Exam start / Sign-off / Transcription initials.

htark Souders Case Manager Disability Managernent Solutions

November 30, 2004

Steven Alfano 3800 Waldo Avenue 13-G Bronx, NY 10463 Rousing D212 12225 Greenville Ave. Swite 1000 -- LB 119 Dellas: TX 7224 Telephone 1.800.352.0611 Ent 5693 Feachwite 860-731-3413 Mark.Soddens@cigne.com

Re:

Claimant:

Steven Alfano

Policyholder:

Weill Medical College

Policy Number:

NYK 1972

CIGNA Life Insurance Company of New York

Dear Ms. Alfano:

This letter is in reference to the captioned Long Term Disability claim.

As of this date, we have not received the information requested from you in our November 9, 2004 letter. Please provide us with the following information by December 21, 2004:

1. The enclosed Supplementary Claim Disability Benefits form.

You may fax this information to the undersigned at 860-731-3413.

A copy of the original request is enclosed with this notice. If this information has already been sent, please disregard this notice.

in addition, please be advised that, as of January 1, 2005, your Gross Monthly Benefit will be subject to a 3% Cost Of Living Adjustment. Your benefit check for the time period of December 3, 2004 through January 2, 2005, will be for the net amount of \$2,282.53. Your new Gross Monthly benefit amount, prior to deductions from Other Benefits, will be \$4,674.60 beginning January 1, 2005.

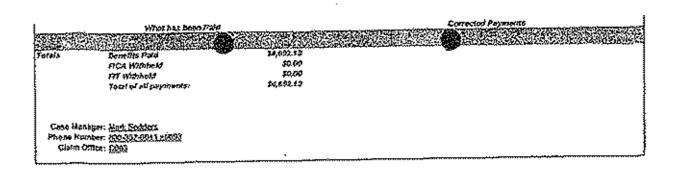
Please refer to the enclosed calculation sheets for details.

Your assistance in providing this information is appreciated and will aid in the prompt handling of the claim.

Sincerely,

Mark Sodders

	<u></u>	<u>.</u>	~~~~~	Disability Ber		Adlustinbit	Version Date: 1/26/00
Para	*****		in the same of the	talescentist the		A	
Date:	11/20/2004		489			***	
Chalesent Hamps	Sinha Alixan		rag-			Postoynojaan (Wall Madeal Calogo Postoy Rumbon (NYK 1977)	
,-,					ľ	relicy Humbert HVK 1977	
Minimulai Boarfit	100,00				······		·······
stenson to respect	pent:	3% Ç(XA)	valne (most)				
	Who	has been	Palet			Соурстов Рауше	W\$
Props bonest:	100	ANXIEGO.			100		
Promo 1 (3111) (50)	(1011200ABA)()	throoms: ()	474560	30.09/01/11/55/11	客	2 3 4 1 - 5 2 4 7 2 3 1 6 1 6 2 6 1 2 7 1 2 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Other Security:		20,720,000	9993 (896) 11 (9 149) SSOI 28 Dive	•	10,	***************************************	1
		tion es	SSOLOR DON'T Fam SSOLOR PROMY	:			1
TAL YAME		***			1	ω	Ì
2004			Tents	has period;	. 1		1
,	NA Roadd		MPOTENING:	\$2,121.03	usv.		1
	FICA	1000 SORO SORO		\$0.00 30.00	N.	positiva a como como como como como como como c	
	FIT Payment Amounts:			52,121.09	1	***********	1
				•	ķ*		
From:1153 Gross Operali Other Screens	i anoma:	typiam lipi:	16Urana - Ini-	CONTRACTOR OF THE STREET	()	<u>8 (7); (1); (6) (22) (5) (6) (8) (3) (3 (8) (8) (4) (7) (</u>	
Other Stewarth		3,100,67	sada 2 bass	MA (P)	8		
		\$50.53	Lau SSO15 UAN		86	B-0000	
Tex Yours					ź.	,	
2004	ı	I	Touto	the partes	W.		
1	Per Bened	\$160.64	४०ल कल्लाङ,	\$560.64			
	FICA			\$0.00 \$0.00	w.		
	ድርኛ የልያያቀቀጠይ ለመማውጣን	\$110.64		\$150,64	200	***************************************	
1							nessaria escribio (United SUSUS)
Cross seach Cross seach	: telegraph :	(Tringungh; !)	this Cana Benefit	or working (13) 174114	1		
Other Benedit:		21,510,00	650		ļ. :	,	
1		7,505	Feln SSD1		ſ :		
THE YOUTS					1		:
	·		Tous	that gorneth	1		
	Nel Banks	\$6.00	ked softer	\$2,669,60 \$3,60	1		
1 :	FEX	200 200 95 000		\$0.00	1.		
	Permant Articult	12/10/40		\$7,403.50	1		
 	acesta e constituidad de la cons	tames and the	0.0000000000000000000000000000000000000	richina acesa culti	á ·	THE PROPERTY OF STREET, SECTION SECTION.	445-4
31/20/12/20/20/20/20/20/20/20/20/20/20/20/20/20	No. of the last of				•		
1			1				
		via manus				1	
							i
1			ua rim			Abolome management by the complete control of the c	3 (5 (6 (6 (6 (6 (6 (6 (6 (6 (6 (6 (6 (6 (6
15. "State 100	864 (15 <u>40) (167</u>		3760 og 165 3350	sarjasnjejani je	1		a responding to the plantage of a stable
		-, -«»					
1							
1							
1		***************************************	•				
							
		 \ \	,				
L				Market and the second of the second	3	020070300003030303030303030303030	rigigi san ay kat wasanan at kasan
2011 D. 2012 14 (19 (19 (19 (19 (19 (19 (19 (19 (19 (19		0.302.000	2 2 7 7 1 1 2 1 2 1 2 7 3		4	12171.4000.0000.0000.0000.0000.0000.0000.0	
			•				-
						-a visaa surkenn	
1							
1						1	
1			•				
i		101011 1111111	•				



×	
ä	
ŝ	
8	
4	

(a) (a)	58 03 - Active	5 AM 90 00	
11124/2004	0670572000	11/19/2004 11:05 AM THE THE 49648 - 01/14/1938	
Due Date: [11/24/2004	SSN (098-44-8648 DOB 01/14/1958 Account # NYK0001972 Incurred Data 05/05/2000 Incident # 513554 Claim Eff Dt-Status 01/21/2003 - Active for COD. for COD.	Lest Changed Date [11/19/2004 11:05 A True True 11:05 A Title 11:05 A	
w-Up	CALEGE Acting on APS User 10	Mark Sodders Las Created By Assigned To	
Task: General Follow-Up Start Date:	unt Namo WEILL MEDICAL I Manager Meth Sodders filu exp TSA tred on 11/09/04 9/04 received today, 11/19/2004 11:05 AM	Last Changed User A Active Contents Type Due Date Ch	

https://dms-acclaim.group.cigna.com/scenza/Task/TaskOTCTASK_FOLLOWUPDisplay.asp?id=10632112&wd=1&ooKey=T... 11/19/2004

OCT-15-2004 14:47 From: CIGNA DALLES

9729521285

Ta:1212 746 8127

9,2

PHYSICAL ABILITY ASSESSMENT

We are evaluating your patient's disability claim in order to determine functional impairment Picase check the boxes corresponding to the patient's level of physical functioning. Fleuse substantiate your findings with medical documentation. (follure to provide the requested reports/data may result in delay in claim determinations).

Patient Name	Spine	Alfras	Date of Birth
Diagnosis(es)/ICD-	9 Code	estimal.	

Throughout an 8-hopr workday, the patient can tolerate, with positional changes and

meal breaks, the following activities for the specified durations: Check if Occasionally Prequently Continuously Not applicable (\$-33%) supported (39.66%) (67-200%) 10 by objective (42,5 brs) (2.5 - 5.5 (5.5 + brs) diagnosis(ts) Indlaga (בדה Sittings 1 **V**----Standing: Walking: Reaching: Overhead Desk Level ď ____ Below Wolst Pine Manipulation: Right: ሎ ¥ Lette .∕ Right: Simple Grosp: X Left: Right: ð---Firm Grasp: Left: <u>ا</u> 10 lbs. Lifting 11-20 lbs. 21-50 lbs. \$1-300 fbs. 100+ lbs. 10 lbs. Corrying. 11-20 lbs. 23-50 lbs. ŧ, 51-100 lbs 100+ lbs.

2,3 Tq; 1212 746 8127 9729521285 OCT-15-2004 14:47 From: CIGNA DRLLAS i = j 4 Check if Frequently Occasionally Continuously Astrogges Not applicable (1.83%) (34-56%) (67-200%) by objective tα (<2.5 drs) CZ-5 - 5.5 (5.5 + bes) diagnosistes) lindlags. ben) Poshing: (Max. Wc.: 10 1) j... **/**---(Max. Wt.: 10/5) Pulling: 7 Climbling: Regular Stairs Regular Ladders Balancing: Stooping: Reccling: Crouching: Crawling: 4 Sceing: Hearing: Smell/Taste: Environmental Conditions: X. Exposure to extremes in heat Exposure to extremes in cold Exposure to wet / humid ď conditions Exposure to vibration Exposure to odors / furnes / particles Can work around machinery Ablity to Work extended shifts/overtime: d-Use lower extremities for foot controls: Please use this space to elaborate on ANY of the above categories: Signature: Name: _ Date: 19/2/07 Medical Specialty: 2325 Phone: __ Address: __ Pederal ID tax number: Please include any objective test or narrative if available.

Thank you for your time. Please return this form in the enclosed addressed cavelope. -15-2884 14:47 From: CIGNA DALLAS

9789521265

7_{0.5}1212 746 8127

DISCLOSURE AUTHORIZATA

Claimant's Name (Please Print):

I AUTHORIZE: any doctor, physician, heater, heatin care practitioner, hospital, clinic, other medical facility, professional, of provider of health care, medically related facility or association, medical exeminer, pharmacy, employee assistence plan. insurance company, health maintenance organization or similar entity to provide access to or to give the company named below (Company) or the Plan Administrator of their employees and authorized agents or authorized representatives, any medical and commedical information or records that they may have concerning my health condition, or health history, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, treatment, diagnoses, prognoses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also include, but is not limited to, information concerning: mental liness, psychiatric, drug or atcohol use and any disability, and also HIV related testing, infaction, illness, and AIDS (Acquired immune Deliciency Syndrome), as well as communicable diseases and generic testing. If my plan administrator opensors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company which administers such medical or disability benefits for the purpose of evaluating any claim that may be submitted by mit or on my behalf for benefits, for evaluating return to employment opponunities, and for administering any feature described in the plan. This information may also be extracted for use in audits or for statistical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparet, insurance company or reinsurer, consumer reporting agency insurance support organization, Claimant's agent, employer, group policyholder, business associate, benefit plan administrator, family members, triends, neighbors or sesociates, governmental agency including the Social Security Administration or any other organization or person having knowledge of me to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have concerning me, my occupation, my activities, employee/employment records, carnings or linences, applications for insurance coverage. prior claim lifes and claim history, work history and work related activities.

LUNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, any amounts payable, return to employment opportunities, and to aeminister any other teature described in the plan with respect to the Claimant. This authorization shall remain valid and apply to all records, information and events that occur over the dutation of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and or my authorized representative may request one. For my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The information obtained will not be disclosed to anyone EXCEPT: a)reinstring companies; b)the Medical Information Bureau, Inc., which operates Health Claim Index (HCI); c)fraud or overinsurance detection butosus; chanyone performing business, medical or legal functions with respect to the claim or the plan, including any entity providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; e)for audit or statistical purposes; f)as may be required or permitted by law; g) as I may further authorize. A valid authorization or court order for information does not waive other privacy rights.

If my medical information contains information regarding drug or alcohol abuse. I understand that my records may be protecte under toderal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ask the party that disclosed information to the Company to pairnit me to inspect and copy the information it disclosed. I understand that I can refuse to sign this disclosure authorization; however, if I do so. Company may deny my daim for benefits pursuant to the plan. The use and lumber disclosure of information disclosed hereunder may not be subject to the Health incurance Portability and Accountability Act (HIPAA).

Signature of Claimant or

Claiment's Authorized Representative:

Relationship. il other than Claimant

Claimant's Social Security Number: 656-144-9646

Company Name:

PACHIBITION ON RE-DISCLOSURE

if the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Foders regulations (42 CFR Part 2) prohibit any person or onlity who receives such protected information from the Company from moving any further disclosure of it without the specific written consent of the person to whom it perfolins, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. The recent rules restrict any use of such protected information to criminally investigate or prosecute any alcohol or drug abusa patient.



9729581205

212 746 NO. 916 P. II

acsimile Transmission Cover Sheet

Mailing !

CIGNA Group Insurance

THIRD REQUEST

	milety (and the first in the second s	Total	£.0 ki) 1,2 ki ki ki ki da bazkara	
Trenduction FAX number 212-746-8127	October 15, 2004	2:00 p.m.	Challeting Pile shootka	
÷ ·	•			

Namo Dr. Rosch		Name Mark Sodders		
		Department		
Company.		CIGNA Disability	Management Solutions	
Piturs 212-746-2879	1	Phono 1.800,362.0611 E		
		Address	L	
лофорд 505 R. 70 th St. Ht. 460		12225 Greenville	VASIDS	
		State 3000, LB 17	79	
New York, NY, 10023		Dallas Texas 752	43	

Фонтифир

¢₽.

Steven Alfano

DOB:

1/14/58

Policyholdin

Weili Medical College NYK 1972

Underwilting Company:

Life Insurance Company of North Avunica

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income) we are in need of the following information:

A completed Physical Abilities Assessment forms (attached).

We ask that you kindly respond by 10/29/01 to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your tax discutification number. If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely.

Mark Sodders

CONFIDENTIALITY NOTICE: If you have received that feedentle in error, picose immediately meetly the sender by relations at the number about. The declarests occumpanying this feedence transmission contain confidencial telephonology. This information is intended only for the use of the individual(s) or could remain about Thank you for your compliance.

l de berein de Company of Morb Angeron Commentus Company de Adrica de Company Company de la Sussessión de Company of Live York

[] Admirated providing Requested

To Fax 6 (cply, tild): 880.731.2507

11/19	· '04		•	·
	ayana-lowers.	eserge 1080s	CLT Nhoa oor of broa	din Calindar ya.
1 m. 10 m. 10 1000	09 . Policy Langue . D: 6/6/00 1 . BSD: 12/3/00	•		
******** *** ***				
	06/08/01 05/08/01		Eavemp	5,933,32
	06/06/01	= 3.4%	Name Name Name Color Color	6,135.05
	06/06/02	= 1.3%		6,214,8
	06/06/03	= 24%		6,282,29
	06/06/04	- Apt time	J.	6,233,21
ang transporter series and the series of the		80\$ =	4,9 86,57	
	error and the second se		· ·	···
	111 "7			

Mark Sodders Case Manager CIGNA Disability Management Solutions



November 9, 2004

Steven Alfano 3800 Waldo Avenue, 13/G Bronx, NY 10463

Routing 212E 12225 Greenville Avenut Suite 1000 LB 179 Dallas, TX 75243-9382 Telephore 880.352.0611 x5693 Facsimile 860.731.2987 Mark Sodders@Clgna.com

CIGNA Group Insurance Life Accident Distribility

Re:

Claimant:

Steven Alfano

Policyholder:

Well Medical College

Policy Number:

NYK 1972

CIGNA Life Insurance Company of New York

Dear Mr. Alfano:

This letter is in reference to the captioned Long Term Disability claim.

A review of our life reveals the need for updated information. One of the provisions of your contract specifies that you may not be considered totally disabled for any period if you are not under the care of a licensed physician. Please complete the following information and return to this office by November 30, 2004:

Supplementary Claim Disability Benefits form.

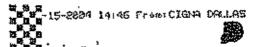
You may fax this information back, attention to the undersigned, to 860-731-2907. Or, a return envelope is enclosed for your convenience.

Your assistance in providing this information is appreciated and will aid in the prompt handling of your claim.

Sincerely,

Mark Sodders

acsimile Transmission Cover Sheet



9729521285

To:1212 746 8127

₽.1

CIGNA Group Insurance Life : Accident - Chimbiath

THIRD REQUEST

Transmit to FAX member 212-746-8127

Date October 15, 2004 2:00 p.m.

Total number of projes (including this shoot).4

Nome

Dr. Roach

Company

Phono 212-745-2879

Address

505 E. 70th St. Ht. 450 New York, NY, 10021

Nama

Mark Sodders

Department

CIONA Disability Management Solutions

1.800.352.0611 Extension 5693

Address

12225 Greenville Avenue

Suite 1000, LB 179 Dallas Texas 75243

OCT 2 B 2007

CONTIN

Commonts

RE:

Steven Alfano

DOB:

1/14/58

Policyholder:

Weill Medical College NYK 1972

Underwitting Company:

Life Insurance Company of North America

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income) we are in need of the following information:

A completed Physical Abilities Assessment form (attached).

We ask that you kindly respond by 10/29/04 to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your tax identification number. If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

Mark Sodders

CONFIDENTIALITY NOTICE: If you have received this factinitie in error, please immediately noisly the student by telephone at the committee above. The decembent accompanying this factballe transmission contain confidential information. This information is intended only for the use of the individual(s) or orbity rounced above. Though you for your compliance.

ባለው Phatelowife Complete ነፃ ቸላላነት ሊያደንሺዋ Сеппмин Семпи Се выше возмение Со COUNTY SITE SOURCE COMPANY OF NEW YORK

() Acknowledgment Requested

To Fax a reply, dist : 880,731,2907

CCT-001, 20, 2004; 1:10PM:1G-10 11/9 Has

9729521025

Table 12 746 NO. 916 F. 7a

PHYSICAL.	ability	ASSESSMI	W.

We use evaluating your patient's disability claim in order to determine functional impoliment Please check the boxes corresponding to the patient's level of physical functioning. Please substantiate your Endings with medical documentation. (Fallure to provide the requested reports/data may result in delay in claim determinations).

Patient Mome	Green	Altono	Date of Birth
Diagnosis(es)/ICD-	9 Code	01/1	SPA-COPA

Throughout an 8-hour workeny, the patient can solerate, with positional changes and

meal breaks, the following activities for the specified discutions: Check II Oceansionabily Continuously Frequently Not applicable supported by abjective (J-23%) (67-100%) (34-66%) ((2.5 Mm) (6.6 + hay) 12.6 - 5.5 diognomis(es) findiage hers) مسيركن Sitting Stonding Walking: Overhead Reaching: Desk Level ø Below Waist Pine Manipulation: Right: ሎ £ Left Φ. Right Simple Grasp: X Left: Right: 0 Firm Grasp: Lefe ₩. 10 lbs. Lifeing: 11-20 fbs. 21-50 lbs. 7 51-100 Pos. 1004 lbs. 10 lbs. Carrying 11-20 lbs. 21-50 bs. 51-100 lbs 1004 lbs.

OCT-001, 20, 2004 1 1:0 IPMCTGHARYPHLAS

9729525205

74,1212 746NO. 916 P. 3,3

	Not applicable to alognosistes)	Constauousty (67-100%) (5,6 + hrs)	Errympilly (24-66%) (2.5 - 6,5 hr()	Occasionally (1.33%) (<2.5 ber)	Check if supported by objective stadiose
Pushing: (Max We: 1971)				4-	
Palling: (Mox. Wt.: 101)	······································				
Climbing: Regular States				V.	
Kegular Ladders				1	
Balancing:				1-	
Stooping:					
Kncellng:	···				
Crouching:].	
Crawlings				*	
Seelpg.	∀-			,	
Hearing:	d.				
Smell/Taste	4	<u> </u>			
Environmental Conditions: Exposure to extremes in heat Exposure to extremes in cold	K	,			
Exposure to wet / humid	ď				
Exposure to vibertion	<i>b</i> -				<u></u>
Exposure to odors / funes / particles Can Work around machinery	<i>y</i>				
Ability to work extended	-		<u> </u>	<u> </u>	
ahifts/overtime: Upe lower extremities for foot controls	-			: d-	
Please use this space to elabora	te on ANY of	the above cate	gorles:		
Name: Keret	7L	Sigr	ature:	4/252	
Medical Specialty: 123 Address: 15-7 Pederal ID tax number:	12 1 T	Date Pho	nture: : <u>(4 4 6 7</u> ne: <u>2 / 2</u>	76 3	7< 8
Please include	any object	ive text or r u for your	arrative i	favailable.	

9729521725

212 746 NO. 916

DISCLOSURE AUTHORIZATIL

Claimanns Name (Please Print):

ALFAND

I AUTHORIZE: any doctor, physician, healer, health care practitioner, hospital, clinic, other medical facility, professional, or provider of health care, modicially related facility or association, medical examiner, pharmacy, employee scalatence plan, insurance company, health mainlenance organization or simbar entity to provide access to or to give the company named below (Company) or the Plan Administrator or their employees and authorized agents or authorized representatives, any medical and nerenedical information of records that they may have concerning my health condition, or health bistory, or regarding any advice, care or treatment provided to me. This information and/or records may include, but is not limited to: cause, beaument, disgricees, progresses, consultations, examinations, tests, prescriptions, or advice regarding my physical or mental condition, or other information concerning me. This may also instude, but is not limited to, information concerning: manial Brices, psychiatric, drug or alcohol use and any dicability, and also HIV related testing, infection, Illnans, and AIDS (Acquired Immune Deficioncy Syndrome), as well as communicable diseases and genetic testing. If my plan administrator sponsors both a disability plan underwritten or administered by Company and a medical plan of any type written by another CIGNA company, the information and records described in this form may also be given to any CIGNA Company wition administers such medical or disability benefic for the purpose of evaluating any cleim that may be automitted by me or on my behalf for bonellis, for evaluating return to employment opportunities, and for admiratering any feature described in the plan. This information may also be extracted for use in audits or for meliatical purposes.

I AUTHORIZE: any financial institution, accountant, tax preparer, instance company of mineurer, consumer reporting agency insutance support organization. Claimant's agent, employer, group policyholden, business associate, benefit plan administrator, turney members, Iriands, heighbors or associates, governmental agency including the Social Security Administration or any other organization or person having knowledge of the to give the Company or the Plan Administrator or their employees and authorized agents, or authorized representatives, any information or records that they have consorring me, my occupation, my activities, employee/employment rocents, comings or finances, applications for insurance coverage. prior claim files and claim history, work history and work related activities.

LUNDERSTAND: the information obtained will be included as part of the proof of claim and will be used to determine displicitly for claim benefits, any amounts payable, return to employment opportunities, and to administer any other leadure described in the plan with respect to the Clearant. This authorization shall remain with and apply to all records, information and events that occur over the duration of the claim, but not to exceed 24 months. A photocopy of this form is as valid as the original and or my authorized representative may request one. I or my representative may revoke this authorization at any time as it applies to future disclosures by writing the Company. The Information obtained will not be thanked to anyone EXCEPT: a)reinsuring companies; b)the Modical Information Bureau, Inc., which operates Health Claim Index (HICI); e)traud or overnationace detection bureaut; d)anyone performing business, medical or logal lunctions with respect to the claim or the plan, including any citify providing assistance to the Company under its Social Security Assistance Program and employers involved in return to employment discussions; ellor multi or dististical purposes; flex may be required or permitted by fam; g) on I may lurise; authorize. A valid authorization or court order (or information does not waive other privacy highle.

If my madical information contains information regarding drug or alcohol abuse, I understand that my records may be protected under federal (42 CFR Part 2) and some state laws. To the extent permitted under law, I can ack the party that disclosed information to the Company to permit me to inspect and copy the information it displaced. I understand that I can refuse to sign this disclosure authorization; however, it I do so. Company may deary my claim for benefits pursuant to the plan. The use and further disclorure of information disclosed horounder may not be subject to the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Cibimant or Chimunt's Authorized Representatives,

Readlonship.

Hother than Claimant

Ctalment's Social Security Number: 099-44-9640

Company Name:

PROHIBITION ON RE-DISCLOSURE

y the medical information contains information regarding drug or alcohol abuse, it may be protected under federal law. Peden regulations (42 CFR Part 2) prohibit any person or onlity who receives such protested information from the Company from making any further discipsure of it without the specific written consent of the person to whom it pertoine, or as otherwise permitted by such regulation. A general authorizotion for the release of medical or other information is not sufficient for this purpose. The Industal rules testrict any use of such protected information to criminally investigate or prosecute any stephol or chip chuse patient.



Message Confirmation Report



OCT-15-2004 02:47 PM PRI

Name

Fax Number 1 9729521205

: CIGNA DALLAS

Name/Number : 91212746812741431

Page : 4 Start Time : OCT-15-2004 O2:46FH FRI Shapped Time : OO'56 Node : STO ECH Resulto

(o.k)

Facsimile Transmission Cover Sheet

CIGNA Group Insurance

THIRD REQUEST

an program and the region of the control of the con		AND THE PERSON NAMED IN COLUMN	
Transmit to FAX minutes	Onto	Tipe	Total number of pages
212-746-8127	October 15, 2004	2:00 р.т.	(Accuracy this cheek4
			
Name		Maran	
Dr. Rosch		Mark Sodders	•
Company		Department CIGNA Disability	Management Solutions
Phone .		Phone	
212-746-2879	•	1.800.352.0611 8	ixtension 5693
Address		Address	
SOS E. 70th St. Ht. 450		12225 Greenville	Avenue
New York, NY, 10021		Suite 1000, LB 17	79
1-21- 1-21-11-11-11-11-11-11-11-11-11-11-11-11		Dallas Texas 7524	43
(
Anna a Anta			

Comments

RE:

Steven Alfano

DOB:

1/14/58

Policyholder:

Weill Medical College NYK 1972

Underwriting Company:

Life Insurance Company of North America

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income) we are in need of the following information:

A completed Physical Abilities Assessment form (attached).

We ask that you kindly respond by 10/29/64 to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your tax identification number. If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely.

Mark Sodders

CONFIDENTIALITY NOTICE If you have received this factinile in error, please immediately notify the sender by thisphone at the number above. The documents accomponying this factimile transmission contain confidential information. This information is intended only for the use of the individual(s) or entity numed above. Thank you for your compliance.

Leit Investice Cophysis of Hotel America Connecticus Gerecus Life Servicine Company CIGNA Life Induspice Company of Flew York

]] Admovfedgment Requested

To Fax a toply, disk: 860,731,2907

PHYSICAL ABILITY ASSESSMENT

We are evaluating your patient's disability claim in order to determine functional impairment Please check the boxes corresponding to the patient's level of physical functioning. Please substantiate your findings with medical documentation. (Failure to provide the requested reports/data may result in delay in claim determinations).

Patient Name	Date of Birth
Diagnosis(es)/ICD-9 Code	

Throughout an 8-hour workday, the patient can tolerate, with positional changes and meal breaks, the following activities for the specified durations:

meat breaks		Not opplicable to diagnosis(es)	Continuously (67-100%) (5.5 + brs)	Frequently (34-66%) (2.5 - 3.5 hrs)	Decessionally (1-33%) (<2.5 hrs)	Check if supported by objective stadians
Sitting:	·····					
Standing:	. <u> </u>					
Walking:						
Reaching:	Overhead					
······································	Dask Level			<u> </u>		
	Below Waist	<u> </u>				
Fine Manipulat	ion: Right:					······································
	Lelt:					
Simple Grasp:	Right:		.//	· · · · · · · · · · · · · · · · · · ·		
	Left:					
Firm Grasp:	Right:					
	i.eft:			,		
Liftlng:	10 lbs.					
	11-20 lbs.					·
	21-\$0 lbs.					
	51-100 lbs.	_				
······································	100+ lbs.					
Corrying:	10 lbs.					
	11-20 lbs.					
	21-50 lbs.					
······································	53-100 lbs				**	
· · · · · · · · · · · · · · · · · · ·	100+ Pos	···		1		

(***		·····
- 11 th 1 11 th					
r	Ret applicable to diagnosis(es)	Continuously (67-100%) (6.5 + brs)	Frequently (34-66%) (2.5 - 5.5 brs)	Occasionally (1-33%) (c2.6 brs)	Check if supported by objective stadings
Pushing: (Max. Wt.:)				<u> </u>	
Pulling: (Max. Wt.:)					······································
Climbing: Regular Stairs				\	······································
Regular Ladders					L-2-294 0
Balancing:			<u> </u>		······································
Staoping:					
Kaceling:					
Crouching:					
Стачівад:			ļ	· ·	· · · · · · · · · · · · · · · · · · ·
Seeing:		· .			v.a.e.e.e.e.e.e.e.e.e.e.e.e.e.e.e.e.e.e.
Hearing:					
Smell/Tastc:		<u> </u>		<u> </u>	· ·
Environmental Conditions:					
Exposure to extremes in heat					<u>'</u>
Exposure to extremes in cold			<u></u>		***************************************
Exposure to wet / humid conditions					
Exposure to vibration		o			
Exposure to odors / furnes / particles				,	
Can work around machinery			<u></u>	•	
Ability to work extended		1			,
shifts/overtime: Use lower extremities for foot					
controls: Please use this space to elabora	te on ANY of	the above cate	gories:		', '
PREESE ROE THO SPACE AS CHANGE	**** *** *****				······································
		···		••••••••••••••••••••••••••••••••••••••	
	······································	······································			·
Name:		Sign	eature:		
Medical Specialty:		Date	-		
Address:		Pho	je:	· · · · · · · · · · · · · · · · · · ·	
Enderal ID tax number:	. <u></u>				
Please include	any object	ive test or D	larrative il Lime	f available."	
<u> </u>	i nank yo	u for your	Litter Loggraphed	envelone	

Nessage Confirmation Report

SEP-14-2004 01:25 PM TUB

Pan Bumbor

: 9729521205

Nome

: CIGNA DALLAS

Namo/Number 91212745812741431

Page

÷

Start Times

: SEP-14-2004 01:26PM TUE

ship bacquia

t 00°35°

Fode

STO DCH

Republics

(O.K)

Facsimile Transmission Cover Sheet



	A principle of the party of the principle of the party of	Contraction of the Contraction o
Transmit to FAX number	Date	Tuno
212-746-8127	September 19, 2004	2:00 p.m.
	•	

2nd Request

Total awarder of pages Pilloekaling this sheelpd

Dr. Keith Roach

Сотрану

Phone

212-746-2879

Address

505 E. 70 St. Ht. 450 New York, NY, 10021

Mark Sodders

Осрафисы

CIGNA Disability Management Solutions

1.800,352.0611 Extension 5693

12225 Greenville Avenue Sulte 1000, LB 179

Dallas Texas 75243

Comments

RE.

Steven Alfano

DOB:

1/14/58

2md Request

In order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income), we are in need of the following information:

A completed Physical Abilities Assessment form (attached).

We ask that you kindly respond by 9/28/04 to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your tax ldentification number. If this request requires a pre-payment, please tell me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

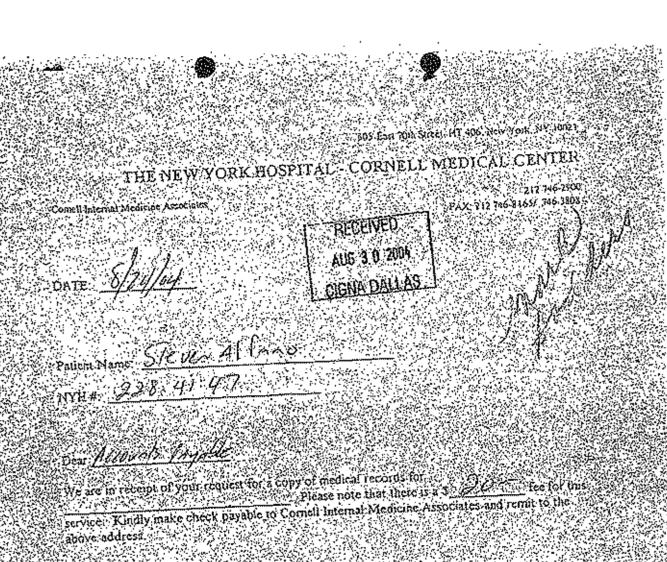
Mark Soddets Case Manager

> CONFIDENTIALITY NOTICE: If you have received this farsimile in error, please immediately notify the sender interpolars that is interpolar if you have received this faisimile in error, please immediately notify the set by interpolar at the number above. The documents accompanying this facionile transmission contain confidential information. This information is intended only for the use of the individualis) of entity named above. Thank you for your confidence.

the Interests Company of Horris Asserts Connecticut General tills Invitable Comp CAGNALLY INDUSTRIE CONTURY of the You

1 | Acknowledgment Requested

To Fax a reply, dist : 060.731.2007

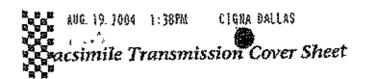


Sincerchy

for Countil Linus and Modicine Associates

Steventuffin

CLICNY 0984



Wedral 0, 15- # 228 4147

CIGNA Group Insurance

Technil to FAX number 212-746-8127

Date August 19, 2004 Tme 2:00 p.m. Total number of pages (including this shoot):4

Negra

Dr. Keith Roach

Company

Pacas 212-746-2879

212-796-2879 Admss

505 E. 70 St. HT. 450 New York, NY. 10021 Name

Mark Sodders

Opportunital

CIGNA Disability Management Solutions

Phone

1.800.352.0611 Extension 5693

Address

12225 Greenville Avenue

Suite 1000, LB 179 Dallas Texas 75243

Commonie

RE: Steven Alfano

DOB: 1/14/58

in order to evaluate your patient's eligibility for Long Term Disability benefits (e.g. lost wage income), we are in need of the following information:

- A completed Physical Abilities Assessment form (attached).
- Copies of your progress notes, including diagnostic test and lab results, from 1/1/02 to the present.

We ask that you hindly respond by 9/2/04 to avoid any delay in your patient's claim for lost wages.

Naturally, we will consider a reasonable charge for this medical information. Please include your tax identification number. If this request requires a pre-payment, please call me at the phone number above or fax (860.731.2907) a fee request to my attention.

Sincerely,

Mark Sodders Cose Manager

CONFIDENTIALITY NOTICE if you have received this facilable in aron, please immediately notify the studenty topologic distribution of the studenty topologic distribution in the decimal containt topologic information. This information is intended only for the use of the individual(s) or entity named above. Trank you for your compliance.

the traversate Computer of North America Commission General Life Insurance Computer Ciona Life Inhamase Computer of Here York

[] Asknowledgment Requested

To Fax is reply, dist : 880,751,2907

US Healthcare US Hea	NI NI NI NI NI NI NI NI	3	TRIAMCINGI USINOPRIL ZESTRIL Z	COME 0.7% CREAM COME 0.7% CREAM COME TABLET / 1 PO COME CAPSULES / SAL SPRAY 20MG/ MG TABLET / 1-2 NO MG TABLET / 1-2 NO	it soply bid at po ad at 1 po ad approximation of a special approximation o	p s	aranat Sarih	
US Healthcare Estation of the part of the programme of the part o	NI NI NI NI NI NI NI NI	3	TRIAMEROS LISINOPRIL ZESTRIL 203 PREVACID 3 IMTREX NA IMITREX SM ASTRIM SM	Cone 0.7% Cream Some Tablet / 1 po c Dane Capsules / Sal Spray 20%G/ MG Tablet / 1-2 in	it soply bid at po ad at 1 po ad approximation of a special approximation o	nah ju	aranat Sarih	
US Healthcare JUFO2010 CD 700.57 SEEP APEA ASCADISCOLLAR GAZZANI CD 700.65 SEMENA UNDER CANANCESSADIA GAZZANI CD 700.65 SEMENA UNDER CANANCESSADIA GAZZANI CD 700.65 SEMENA UNDER CANANCESSADIA GAZZANI CD 700.65 SEMENA UNDER CONTROLLAR GAZZANI CD 700.65 SEMENA CONTROLLAR CONTROLLAR CD 700.65 SEMENA CD 700.65 SEMEN	01 01 02 02 02 02 02 03 03 03 03 03 03 03 03 03 03 03 03 03	3	TRIAMEROS LISINOPRIL ZESTRIL 203 PREVACID 3 IMTREX NA IMITREX SM ASTRIM SM	Cone 0.7% Cream Some Tablet / 1 po c Dane Capsules / Sal Spray 20%G/ MG Tablet / 1-2 in	it soply bid at po ad at 1 po ad approximation of a special approximation o	nah ju	aranat Sarih	
SO Party Shield STRENGER LIBRORIDADE CONTROL DO FOR MARKET STRENGER RECEIVED CONTROL SO SON HARRING TO PROST ATTROCATION OF THE STRENGER CONTROL SO SON HARRING RECEIVED CONTROL SO SON HARRING RECEIVED CONTROL SO SON HARRING RECEIVED CONTROL SO SON HARRING THE SON HARRING RECEIVED CONTROL CO TICH ARTHROPACH TO CHARRING RECEIVED CONTROL SO SON DESCRIPTION OF THE RECEIVED CONTROL SO SON DESCRIPTION OF THE RECEIVED CONTROL SO SON DESCRIPTION OF THE RECEIVED CONTROL CO TICH ARTHROPACH TO THE RECEIVED CONTROL SO SON DESCRIPTION OF THE RECEIVED CONTROL SO SON OF THE SEE NOTION VANC ACCEPTANT OF THE CONTROL CO TICH SON THE SEE NOTION VANC ACCEPTANT OF THE CONTROL OF THE CONTROL OF THE CONTROL OF T	DIADIS DI			ng tablet ec 🕮	pp qq	. v		
KOOGISSO MINT MAECIASII HOST 19550A) - 19570 KOOGISSO MINT MAECIASII HOST 19550A) - 19570 KOOGISSO MINT MAECIASII HOST 19550A) - 19570A	##5540 FP		OXYCONTIN	YABLET / 1 tob på	4) 5		••••	·

Steven Alfano VYH# 228-41-47 01/18/02 00:00

CORNELL INTERNAL MEDICINE ASSOCIATES

Pallent Name: ALFANO, STEVEN History #: 2284147 Accession #: 98374556 Scc Security: 099449648 Date of Sinh: 01/14/58 Sex: M Ordered by: Specimen Date: 01/18/2002 00:00 Report Date: 01/19/2002 08:18 Status: Final

COMP METABOLIC PANEL 2-60 U/L ALT 33 U/L 2-50 19 AST U/L 20-125 107 ALKALINE PHOSPHATASE 0.8-2.0 1.8 A/G RATIO gt(f). 2.2-4.2 GLOBULIN, CALCULATED 2.8 3,5(4.9) g/dt. ALBUMIN g/dL 6.0-8.3 PROTEIN, TOTAL 7.3 ag/dL 9.6 8,5-10.4 CALCIUM 6.0-25.0 BUNICREATININE RATIO 15.5 mg/dl_ 0.5-1.4 CREATININE 1.1 w0/dL 7-25 UREA NITROGEN 17 21.33 mmc//L CARBON DIOXIDE 22 mmol/L 98-110 103 CHLORIDE mmol/L 3.5-5.3 **POTASSIUM** 4.2 regist. 65-109 GLUCOSE, FASTING

> Glycose was performed on the gray-top tube that we received with your chem-screen order, if you have any questions or concerns, please call our client services department at 800-631-1390.

135-146 mmol/L 142 SODIUM 3.5-5.3 mmot/L POTASSIUM 4.2 98-110 103 mmol/L CHLORIDE mmolit 21-33 22 CARBON DIOXIDE ան/գլ UREA NITROGEN 7-25 mg/dL 0.5-1,4 CREATININE 1.1 6.0-25.0 **BUNICREATININE RATIO** 15.5 mg/di. 8.5-10.4 CALCIUM 9.6 6.0-8.3 g/dL 7.3 PROTEIN, TOTAL g/dL 3.5-4.9 4.5 ALBUMIN g/dt. 2.2-4.2 GLOBULIN, CALCULATED 2.8 0.8-2.0 A/G BATIO 1.6 mg/dl. 0.20 - 1.50BILIRUBIN, TOTAL 0.45 20:125 ALKALINE PHOSPHATASE U/L 107 2-50 19 U/L Λ\$T 2-60 WL. 33 ALT 22.0-34.0 30.9 Seconds PIT PROTHROMBIN TIME 0.90-1.10 Ratio INFI 0,93 No Anticoagulant, Normat 0.9 - 1.1Oral Anticoagulant, Standard Dose 2.0 - 3.0 Oral Anticoagulant, High Dose $2.5 \cdot 3.5$

65-125 GLUCOSE 101 mg/UL.

Steven Alfaho NYH# 228-41-47 01/18/02 00:00 Page 2

CORNELL INTERNAL MEDICINE ASSOCIATES

The glucose CBC W/ DIFF & PLT	reference (8)	nd al sgr	sed on a non-t	asting state.
W8C	7.2	Thouse	ncl. 3.8-10.6	i.
ABC	5.10	Mill/mcl		
· :	15.2		/dt 13.2-	17.1
HEMOGLOBIN		% %		
HEMATOCRIT	44,1		80,0-100,0	V.V
MOV	86.5	Œ,		
MCH	29.8	99	27.0-33.0	
MCHC	34.4	g/t/l.	32,0-36,0	
ROW	13,2	. %	11,0-15.0	140-400
PLATELET COUNT			ThousimicL	140-444
MPV	8.2	%.	7,5-11.5	
TOTAL NEUTROPI	12 10 10 10	66.4	%	
TOTAL LYMPHOCY		24,0	%	
MONOCYTES.%	6.1		%	
EOSINOPHILS,%	2.8	9	*	
BASOPHILS,%	9.7	%		
NEUTROPHILS, AS	SOLUTE	4781	ceils/m	
LYMPHOCYTES, A	380LU1`E	1728	celisin	· · · · · · · · · · · · · · · · · · ·
MONOCYTES, ABS	OLUTE	439	cells/mo	
EOSINOPHILS, ABS		202	cells/mcl	
BASOPHILS, ABSO		50	cess/mct.	0-200
DIFFERENTIAL				
An instrume	aireachta ta	was pedi	orméd.	
Please note	DEM TOJOTON	ж галдо		
URINALYSIS.COMP		~		
COLOR	Yellow		Yellow	
APPEARANCE	Clear		Ciear	
GLUCOSE,OL	Negat	lve		zgative
BILIAUBIN	Negativo			!
KETONES	Negaliye	e a		aliye
SPECIFIC GRAVIT			1,00	1-1.030
BLOOD	Negative		Negative	
PH	7.0	į	5,0-8.0	
PROTEIN, TOTAL		(1+)	mg/dL	Negative
NITRITE	Negative	, ,	Negative	
LEUKOCYTE ESTI	FRASE	Negative		Negative
SQUAMOUS EPIT	RELIAL CELL	S 3.5	/hpt	0-5/hpt
WBC	0.5	Appl	0-3/hpt	
BACTERIA	None	/tep	anold k	
RSC	0-2	ന്റി	0-2/hpf	
MUÇUS	Trace	f #pt	•	
44-44-4-4-				

Steven Alfano VYH# 228-41-47 01/18/02 08:39

CORNELL INTERNAL MEDICINE ASSOCIATES

Progress Note: Steven Alfano / January 18, 2002

CIMA/OMC Preoperative Evaluation Requested by: Dr. Michael Alexaides

Referring Physician's address/telephone #: 159 E 74th St., New York

fax 212 439 6855

Playmed surgery; urthroscopic shoulder surgery, decompression

Surgery dute: 1728/02

HPI: 44 year old man with R shoulder separation, operated on before for rather cuff tear, now for arthrescopic decompression, Major complaint is pain, limitation of movement.

PMB: severe spinal stenosis - LS-S1 HTW - good control headaches - relieved by iminex

Commany artery disease: none Disheres mellitus requiring therapy other than diet: never COPD: no diagnosis, no symptoms Asthua; autoc

PSH; previous shoulder surgery, tonsils, soft palate reduction for sleep apaca

Flux: HTN, on CAD

Sha: lives with wife, 2 children Waskinging to get disability, unable to work secondary to lead pain Relationships: lives with wife, succeed about financial issues, health concern Cigarette user 30 pack-years Alcohol: rare Drags: na

Heigh maintenance: Immusications: Last 'ति: ऐक्टक' । क्वक्टकरेड Fig vacqueet doesn't wort Person/vers and indicated PPD: our indicated

Correst Medications: vious \$0 qd fisionoril 10 ed previoud 30 q 145 ASA Kt mg od інвінох пакай крупу 20

Allergies: Collegue - tentoco

Review of Systems:

Steven Alfano NYH# 228-41-47 01/18/02 08:39

Page 2

Filed 07/28/2008

THE NEW YORK HOSPITAL CORNELL MEDICAL CENTER

CORNELL INTERNAL MEDICINE ASSOCIATES

Problems with anombesimageer

Blooding problems:none

Exercise: limited by spinal stenosis, limited by back pain, weakness in teg

Blocks walked before needing to rest: <1

Flights of steps climbed before needing to rest: 1

Reason for stopping: loss of strength in legs

Palm: no problems

Card; no chest discomfort or palphations

GI: constipation

GU: arinary retention, evaluated by prology - not left to need treatment

Objective:

DP Right: 140/104 | Left: 140/100 | Polse: 88 | Wr. 298 | Ht. 613" HEBRY: PERRL, EOMI whost nystogmus, discs that B. to H/E. OP.TM's and nares cir, no sinus tenderness. Neckt an LN, no thyromegaly/nodules, carotida 2+B, no bruits. Lungs and Chest: C'fA and P. No axillary or SC LN. Cor: PMI nonentarged, nondisplaced, RRR s1s2, no migh.

Back: no spinous tendemess or scoliotis. No CVAT.

Abd: BS active, NT, ND, no HSM.

Recast;

Lymphasics: No axillary, suprochavious, or inguited LAN.

Ext: DP 24 B. no edeina.

M/S; moderne R shoulder impingement

Nource Numbered, Strength 5/5 B UE and LE, DTR's 2+ throughout

Skin: No cashes or dysplastic nevi.

GU: testes NL size, no masses, no serotal masses, on ingoinal herma B.

Data (as clinically indicated):

Chemistry hattery:

ÇBC:

PT/PTT:

ECG:

Chest X-my:

Suessiest: not indicated

Impression:

how risk for planned procedure

Recommendations:

Kenta Roach, MD

Steven Alfano NYH# 228-41-47 02/12/02 14:09

CORNELL INTERNAL MEDICINE ASSOCIATES

Progress Note: Steven Alfano / February 12, 2002

Subjective: 44 year old man with

spinal stenosis

needs evaluation for social security

Objective:

BP 130/90 P 88 bpm Wt 300 lbs Height 6ft 3in quads 4/5 + SLR bilaterally al sensation decreased L patellar reflex

Chrient Medications:

TRIAMCINOLONE 0.1% CREAM / apply bid VIOXX 50MG TABLET / 1 tab po qd CELEXA 20MG TABLET / I po qd ZESTRIL ZOMG TABLET / I po qd PREVACID 30MG CAPSULES / I po ed IMITREX NASAL SPRAY 20MG/SPRAY / I spray intranspolly pro IMITREX SOMG TABLET / 1-2 tabs with onset of migrain ASPIRIN SIMG TABLET EC / 1 po qd

Allergles:

Impression:

Plan: forms filled out If with surgery pro

RTC

Kehh Roach, MD

Sleven Alíano NYH# 228-41-47 b5/23/02 12:29

HSS

MRI LOWER EXTREMITY

CORNELL INTERNAL MEDICINE ASSOCIATES

Dr. Michael Alexiades

IMPRESSION:

Magnetic resonance imaging of the right hip demonstrating superficial cartilage loss over the hip joint, borderline acetabular dysplasia and a tom, hyperplastic and degenerated anterior acetabular labrum.

There is a marrow replacement process affecting the left femur which overall has a non-aggressive appearance. Differential possiblities are noted, as above.

Dictated by Hollis Potter M.D.

Steven Alfano NYH# 228-41-47 06/05/02 00:00

CORNELL INTERNAL MEDICINE ASSOCIATES

Patient Name: ALFANO, STEVEN Nistory #: 2284147 Accession #: 43218721 Soc Security: 089449648 Date of Birth: 01/14/58 Sex: M Ordered by: Specimen Date: 06/05/2002 00:00 Report Date: 06/06/2002 02:18 Status: Final

COMP METABOLIC PANEL GLUCOSE, FASTING

65-109 mg/dL

Glucose was performed on the gray-top tube that we received with your chem-screen order. If you have any questions or concerns, please call our client services department at 800-631-1390.

135-146 mmoW. 141 SODIUM mmol/L 3,5-5,3 POTASSIUM 4.2 Alomm 98-110 CHLORIDE 103 21-33 mmol/L CARBON DIOXIDE 22 7-25 UREA NITROGEN 19 mg/dl. mo/dl_ 0.5-1.4 1 1 CAEATININE 6.0-25.0 **BUNICHEATININE RATIO** 17.3 mg/dL 8.5-10.4 9.6 CALCIUM g/dL 6.0-8.3 PROTEIN, TOTAL 7.4 g/dt. 3.5-4.9 4.7 ALBUMIN 2.7 22-4.2 g/dil_ GLOBULIN, CALCULATED 0.8-2.0 A/G RATIO 1.7 0.20-1.50 mg/dl. 0.73BILIRUBIN, TOTAL U/L 20-125 ALKALINE PHOSPHATASE 120 2-50 U/L 21 AST 2-60 36 UA. ALT Seconds. 22,0-34.0 32.9 ΪT٩ PROTHROMBIN TIME Ratio 0.90-1.10 0.95 3NPL 0.9 - 1.1No Anticoagulium, Normel Oral Anticoagulant, Standard Dose 2.0 - 3.0 Oral Anticoagulant, High Dose 2.5 - 3.5

GLUCOSE

102

mg/dL

65-125

The glucose reference range is based on a non-tasting state.

CBC W/ DIFF & PLT Thous/mcL 3.8-10.8 WBC 7.5 Millimot 4,20-5.80 5.28 RBC g/dl. % HEMOGLOBIN 13,2-17,1 15.5 38.5-50.0 HEMATOCRIT 44.8 84.8 Ēζ 80.0-100.0 MÇV 27.0-33.0 29.4 ρg мсн ġ/dĻ 32.0.36.0 34.7 MCHC 11,0-15.0 12.4 % HOW 140-460 Timeug/mct. 237 PLATELET COUNT ₩, 7.5-11.5 MPV TOTAL NEUTROPHILS.% **67.8** %, TOTAL LYMPHOCYTES.% 22.9 %



CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano NYH# 228-41-47 06/05/02 00:00 Page 2

6.6 MONOCYTES,% % 2.6 **EOSINOPHILS.%** % DASOPHILS,% 0:1 Cells/mcL 1500-7800 5153 NEUTROPHILS, ABSOLUTE Cells/mcL 850-3900 LYMPHOCYTES, ABSOLUTE 1740 Cells/mcL 200-950 Cells/mcL 50-550 502 MONOCYTES, ABSOLUTE EOSINOPHILS, ABSOLUTE 198 Cells/mcl. 0-200 8 BASOPHILS.ABSOLUTE DIFFERENTIAL

An instrument differential was performed. URINALYSIS, COMPLETE Dark Yellow Yellow COLOR Clear APPEARANCE Clear Negative Negative mg/dL GLUCOSE, OL Negalive Negative BIURUBIN Negative mp/dL KETONES Negative 1.085 H 1,001-1,030 SPECIFIC GRAVITY Negative Negative BLOOD 5.0-8.0 PH 6.0 mg/dL Negative PROTEIN, TOTAL, OL 30 (1+) Negative Negative NITAITE Negative Negative S 3-5 LEUKOCYTE ESTERASE /hpf 0.5SQUAMOUS EPITHELIAL CELLS mor 0.3 WBC 0.2None None /hpl BACTERIA mpf 0.2 RUC None

Steven Aliano NYH # 228-41-47 06/11/02 17:58

CORNELL INTERNAL MEDICINE ASSOCIATES

Progress Note: Steven Alland 1 June 11, 2002

Subjective: 40 year old mus with

preoperative visit - no changes since last visit 1/02

femur tesson - reassured by ordropaedic encologist dx LSMFT (? liposeterosing myxofibrous tumor)

depression - feeling better with basign diagnosis above

esceide dysfunction - also contributing to depression

Objective:

BP 124784 P R8 BPM W1 298 LBS Height 6FT 3IN

HEENT: PERRL, EOMI whom nysiagmus, discs flat B, no H/E. OP, TM's and narchelt, no sinus tenderness.

Neck: no LN, no thyromegaly/nodules, carotide 2+B, no brains.

Lungs and Chest: CTA and P. No axillary or SC LN.

Cor: PMI uncentarged, nondisplaced, RRR s1s2, no m/g/r.

Ruck: on spinors tenderness or realizais. No CVAT.
Abit: BS active, NT, ND, no HSM.
Ropal;
Lyapphanics: No axillary, supractaricular, or inguinal LAN.
Ext: OF 2+ 8, no edoma.
M/S: maderate R shoulder impingement
Neuro; Nonriveal. Strength 5/5 B UE and UE. OTR's 2+ flatenghous.
Skin: No netics or dysplastic pavi.
GU: testes: NL see, no masses, no scroud masses, no inguinal bernia 8.

Current Medications:

VICODIN 5/500 TABLET / 1 tab po q 4 h pm
TRIAMCINOLONE 0.1% CREAM / apply bid
VIOXX 50MG TABLET / 1 tab po qd
CELEXA 20MG TABLET / 1 tab po qd
ZESTRIL 20MG TABLET / 1 po qd
PREVACID 3/MG CAPSULES / 1 po qd
IMITREX NASAL SPRAY 20MG/SPRAY / 1 spray intiquasally pm
IMITREX 50MG TABLET / 1-2 tabs with ouser of migraba
ASPIRIN 8/MG TABLET EC / 1 po qd

Altergies:

tempressions:

Plan: tow risk for planned surgery



CORNELL INTERNAL MEDICINE ASSOCIATES

Steven Alfano NYH# 228-41-47 06/11/02 17:58 Page 2

New medications: VIAGRA 50MG TABLET / 1 tali po 1-2 li a inferentiste

software test WELLBUTRIN SR 150MG TABLET/ I tob po bid may have benefit in depression

RTC

Keith Roycls, MD

Steven Alfano -NYH# 228-41-47 08/08/02 13:53

CORNELL INTERNAL MEDICINE ASSOCIATES

HSS May 6, 2002

Examination of the Right Hip and Left Hip and Proximal Femur

IMPRESSION:

Large non-aggressive bony lesion expands and remodels the proximal femur from the femoral neck throught the proximal shaft and has matrix calcification, compatible with a chondral lesion. Bone scan is recommended to assess activity of the lexion. Chondrosurcoma is in the differential.

L. Daniel Neistadt, MD 008

Steven Alfano NYH # 228-41-47 09/27/02 15:48

CORNELL INTERNAL MEDICINE ASSOCIATES

Progress Note: Steven Alfano / September 27, 2002

Subjective: 44 year old man with

fow book pain - got social accurity disability

femuricsion - reassured by orthopaedic encologist dx LSMFT (? lipoxelerosing myxolibrous tomor)

depression - feeling better with benign diagnosis above doing botter with Wellburin

preprite dysfunction - also contributing to depression got prescription

quit smoking

bemia eto pain under R testiele worse after sex

hip pain - L sided - only once

HTN - on Zestill Objective:

BP 130(90) by P 80 bpm Wt 293 lbs Height GFT 31N emall bulging, no limak harnistion

Correst Medications:

VIAGRA 50MG TABLET / 1 teb po 1-2 h a intercourse WELLBUTRIN SR 150MG TABLET / I tab po bid VICODIN 5/500 TABLET / 1 tab po q 4 h pra TRIAMCINOLONE 0.1% CREAM / apply hid by order I \ TajaaT DMG XXQIV CELEXA 20MG TABLET / 1 po qd ZESTRII, 20MG TABLET / I pa qs PREVACID 30MG CAPSULES / 1 po 48 IMITREX NASAL SPRAY TOMO/SPRAY / 1 spray introduced by the IMITREX SOME TABLET / 1-2 tobs with onset of migram ASPIRIN SIMO TABLET EC/ 1 po qu

Allergies:

(mpression)

Manageassored relicinia

depression - herter

Steven Alfano NYH # 228-41-47 09/27/02 15:48

Page 2

THE NEW YORK HOSPITAL CORNELL MEDICAL CENTER

CORNELL INTERNAL MEDICINE ASSOCIATES

back pain - pt plans to get back surgery eventually

Refilled: WELLBUTRIN SR 150MG TABLET / 1 cab portion VICODIN 5/500 TABLET / 1 cab port 4 to part

RTC

Keith Reach, MD



Steven Atlano NYH# 228-41-47 12/11/02 00:00

CORNELL INTERNAL MEDICINE ASSOCIATES

Patient Name: ALFANO, STEVEN History #: 2284147 Accession #: 90110627 Soc Security: 099440646 Date of Sidn; 01/14/58 Sex: M Ordered by:

Specimea Date: 12/11/2002 00:00 Report Date: 12/14/2002 12:35

Status: Final

TESTOSTERONE, TOT & FREE TESTOSTERONE, %, FREE TESTOSTERONE, FREE TOTAL TESTOSTERONE

2.8 H Percent 1.0-2.7 50.0-210.0 մու^նն 93.2 260-1000 336 ngidi.

Steven Allano NYH# 228-41-47 12/11/02 14:04

CORNELL INTERNAL MEDICINE ASSOCIATES

Progress Note: Steven Alfano / December 11, 2002

Subjective: 44 year old man with auted mass in mouth

low back pain - got social security disability taking Vinex, improfen, Victoria

femur lesion - reassured by orthopoedic opcologist dx LSMFT (7 liposelerosing myzofibrous tutnor)

depression - feeling bener with benign diagnosis above doing bener with Wellbaurin

creetile dysfunction - also contributing to depression gen prescription

quic enroking

bernig che pain onder Riestitle worse, niligatisé a

hip prin - L sided - only once R sided labout tear

HTR - on Zexuil

SH: did get disability financially doing much better

Objective:

BP 136/88 P 92bpm RR 12 Wt 283,5lbs Height 6FT 3IN looks like root of wisdom tooth - supposedly all removed

Current Medications:

VIAGRA SOMO TABLET / I tab po 1-2 h a intercourse WELLBUTRIN SR ISOMG TABLET / I rab po bid VICODIN 5/500 TABLET / I tob po q 4 h pro TRIAMCINOLONE 0.1% CREAM / apply bid VIOXX SOMG TABLET / I tob po qd CELEXA 20MG TABLET / 1 po qd ZESTRIL 20MG TABLET / 1 po qd PREVACID 30MG CAPSULES / 1 po gd